The Family Medicine Clinic
P. O. Box 200185
12 Medical Drive
Cartersville, Georgia 30120

PATIENT INFORMATION

Patient Name (PLEASE PRINT)	Social Security Number	Date of Birth	Age	Sex	Marital Status
Mailing Address	City and State		Zip Code		Phone #
Home Address	City and State			Zip Code	
Cell Phone:	Work Phone:				
Email Address:	Language	Race:		Ethinicity: Hispanic Non-Hispanic	
Patient or Parent's Employer	Occupation (Indicate if you are a student)	# Years Employed		Business Phone #	
Employer Street Address	City and State			Zip Code	
Spouse or Parent's Name	Social Security Number			Date of Birth	
Spouse or Parent's Employer	Occupation (Indicate if you are a student)	Years Employed		Business Phone #	
Employer's Address	City and State			Zip Code	
Emergency Contact	Street Address, City and State		Zip Code	Home Phone #	

INSURANCE INFORMATION

Person Responsible for Payment	Street Address, City and State		Zip Code	Home Phone #
Primary Insurance Company (Indicate if you have Medicare)	Member ID (or Medicare #)	Group #		Effective Date
Primary Insured's Name	Date of Birth	Relationship		Copay
Secondary Insurance Company	Member ID (or Medicare #)	Group #		Effective Date
Secondary Insured's Name	Date of Birth	Relationship		Copay
Are you retired? If Yes, when did you retire?	Are you disabled? If yes, when were you deemed disabled?			Is Medicare Primary?

All professional services rendered are charged to the patient/Guarantor. Necessary forms will be completed to help expedite insurance carrier payment. However, **"the Patient is responsible for all fees regardless of insurance coverage"** . It is also customary to pay for services when rendered unless other arrangements have been made in advance with our Billing Department.
I request that payment of authorized Medicare and/or other insurance company benefits be made to The Family Medicine Clinic for any services furnished to me by the party/physician who accepts assignment.
I herby authorize The Family Medicine Clinic to render professional services and/or diagnostic testing to myself or my dependents.
I authorize providers and staff to release any and all information with respect to my physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, mental health and any non-medical information to any licensed physician, medical provider, hospital, medical facility, pharmacy, or insurance company by mail or fax. This is only done if we have referred you to another physician or at your request or the request of your insurance carrier. This information is released only when needed to provide continuity of care for you or your insurance carrier. I herby assign to the physicians all payment for medical services rendered to myself or my dependents.
For any reason a payment I have made is returned due to lack of funds, I am responsible for any fees that may be applied to my account or my dependents. Such as NSF/returned check fees, late fee or non-payment fees. Non-payment could result in the above information being released for legal collection and could affect my credit rating. I understand in the event my account is turned over to collections, I will be responsible for all collection fees (35% of amount owed), attorneys fees, court costs, etc.
I have completed this form completely and I certify that I am the patient or general agent duly authorized to furnish the information requested.

Signature _____ Date _____